# Hope Medical Clinic Minor Patient Profile (under age 18)

***Please Print***

| [1]Patient Legal First Name | [2]M I | [3]Patient Legal Last Name | [4]Date of Birth MM/DD/YYYY | [5] ☐ male ☐ female | [6]Today's Date MM/DD/YYYY |
|---|---|---|---|---|---|
| [7]Parent/Legal Guardian's First Name | [8]M I | [9]Parent/Guardian's Last Name | [10]Relationship to patient | | |
| [11]Parent/Legal Guardian's First Name | [12]M I | [13]Parent/Guardian's Last Name | [14]Relationship to patient | | |

[15] Patient's Ethnicity (mark 1) ☐ Am Indian/Alaska Native ☐ Asian ☐ Black/African ☐ Hispanic/Latino ☐ Middle Eastern ☐ Native Hawaiian/Pacific Islander ☐ White non-Hispanic ☐ Other ☐ Unknown

[16]Patient's primary language Spoken: [17]Patient's religion/church:

[18]Has the patient received healthcare elsewhere in the last two years? ☐ no ☐ yes

[19]Does patient have MiChild, Healthy Kids, or other health coverage? ☐ no ☐ yes

## [20]MEDICATIONS

[21]**Allergies:** Check here if the patient has ***NO*** allergies to medications ☐,
or list below the medications and substances to which he/she is allergic or has a bad reaction**:**

| Medication/substance name | Describe Reaction | Medication/substance name | Describe Reaction |
|---|---|---|---|
| | | | |
| | | | |

[22]**Current Medications:** List all medications the patient is currently taking, for what condition, and for how long:

| Medication name | Condition | Approximate start date |
|---|---|---|
| | | |
| | | |
| | | |

[23]**Immunizations:** Please list the last known date the patient received each of the following vaccines
(Note: Hope Medical Clinic cannot provide immunizations or determine immunization status. These services are available at your local health department )

| Diphtheria | MMR | Tetanus |
|---|---|---|
| Hepatitis A | Polio | Varicella |
| Hepatitis B | TB | Other |
| | | |

## [24]PERSONAL AND FAMILY HEALTH HISTORY

[25]**Disabling physical or mental impairments –** check each condition that reduces patient's ability to function:
☐ mobility problems (use of arms or legs) ☐ mental or learning problems ☐ hearing problems ☐ vision problems

[26]**Patient's Early Childhood Development:** For patients aged **four years or younger**, or if the information is important, please enter the **approximate age** at which the patient reached each developmental level

| Smile | Crawl | Talk in sentence | Read |
|---|---|---|---|
| Hold up head without support | Walk without support | Toilet trained days | |
| Sit up without support | Talk | Toilet trained nights | |

[27]**Surgeries and Hospitalizations:** List the approximate date and reason for each surgery and hospitalization

| Date | | Date | |
|---|---|---|---|
| | | | |
| | | | |

↓ Please turn over and complete back ↓

| [28]**Patient's Health History:** Check the box for each condition experienced by the patient or his/her family members | Patient | Mother | Father | Siblings | Grandparents | | Patient | Mother | Father | Siblings | Grandparents |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alcoholism/substance abuse | | | | | | Liver disease/hepatitis | | | | | |
| Arthritis/joint disease | | | | | | Measles, mumps, chicken pox | | NA | NA | NA | NA |
| Asthma/hay fever/ emphysema/lung disease | | | | | | Mental health (depression/anxiety/other) | | | | | |
| Birth defects or injuries | | | | | | Menstrual problems | | | | | |
| Blood disorders | | | | | | Positive PPD/TB | | | | | |
| Bowel/bladder problems | | | | | | Rheumatic fever | | | | | |
| Cancer (specify types below) | | | | | | Seizures/epilepsy | | | | | |
| Dental problems | | | | | | Sexually transmitted disease | | | | | |
| Diabetes | | | | | | Sickle cell anemia | | | | | |
| Frequent colds, sore throat, earaches (4 or more per year) | | | | | | Skin conditions, rashes | | | | | |
| Hearing problems | | | | | | Speech problems | | | | | |
| Heart disease/chest pain/heart attack | | | | | | Stroke | | | | | |
| High blood pressure | | | | | | Thyroid | | | | | |
| Kidney disease | | | | | | Vision problems | | | | | |
| Learning disabilities (ADD/ADHD/other) | | | | | | | | | | | |

## [29]Patient's Health Habits

| | | | | |
|---|---|---|---|---|
| [30]Has the patient ever smoked or chewed tobacco? ☐ no ☐ yes | How many cigarettes/ times a day? | At what age did he/she start? | When did he/she quit? | Would he/she like to quit? ☐ no ☐ yes |
| [31]Does the patient use recreational drugs? ☐ no ☐ yes | What kind? | How often? Per day/week | Would he/she like to quit? ☐ no ☐ yes | |
| [32]Does the patient use alcohol? ☐ no ☐ yes, what kind? | How often per day/week | Would he/she like to quit? ☐ no ☐ yes | [33]Hours per day patient watches TV or Internet? | |
| [34]Is the patient concerned about HIV/AIDs or STD exposure? ☐ no ☐ yes | [35]Number of meals patient eats daily: | [36]Number of times patient exercises weekly: | [37]Average amount patient sleeps daily: | [38]Does patient use seatbelts? ☐ no ☐ yes |

[39]Please explain any problems specified above, or list any other chronic disorders the patient may have: ____________________

________________________________________________________________________________________________

________________________________________________________________________________________________

[40]Please list and explain any difficulties involved in the patient's prenatal development, delivery, or post-delivery period: ________

________________________________________________________________________________________________

________________________________________________________________________________________________

[41]**Emergency Contact:** Name of adult other than parent or guardian who may accompany minor to visits and make care decisions

________________________________________ Phone ______-_________________ Relationship____________________

[42]I hereby authorize Hope Medical Clinic, including its staff and volunteers, to administer any treatment deemed necessary for my or subject patient's care until revoked in writing.

________________________________________ ________________________________________________

☐parent or ☐guardian (check one) signature Printed name

Reviewed by Hope Clinician _______________________________ date ____________________________